TITLE 13 INSURANCE
CHAPTER 10 HEALTH INSURANCE
PART 36 HEALTH CARE AFFORDABILITY FUND

13.10.36.1 ISSUING AGENCY: New Mexico Office of Superintendent of Insurance ("OSI").
[13.10.36.1 NMAC – N, 5/1/2022]

13.10.36.2 SCOPE: These rules govern the establishment and provision of a Health Care Affordability Plan and administration of the Health Care Affordability Fund (the "Fund").
[13.10.36.2 NMAC – N, 5/1/2022]

13.10.36.3 STATUTORY AUTHORITY: Section 59A-23F-12 NMSA 1978 (the "Health Care Affordability Plan").
[13.10.36.3 NMAC – N, 5/1/2022]

13.10.36.4 DURATION: Permanent.
[13.10.36.4 NMAC – N, 5/1/2022]

13.10.36.5 EFFECTIVE DATE: May 1, 2022, unless a later date is cited at the end of a section.
[13.10.36.5 NMAC – N, 5/1/2022]

13.10.36.6 OBJECTIVE: These rules establish policies, procedures, and controls for the establishment and maintenance of a *"Health Care Affordability Plan"* as funded by the *"Health Care Affordability Fund"* to achieve the public policy purposes in the manner prescribed under Sections 59A-23F-11 and 59A-23F-12 NMSA 1978.
[13.10.36.6 NMAC – N, 5/1/2022]

13.10.36.7 DEFINITIONS: Terms are as defined in the Insurance Code, and as supplemented below.

A. "Advance state payments" means marketplace affordability program payments by the fund to a participating health insurance issuer on a monthly basis to lower premium and state out-of-pocket assistance for consumers.

B. "Affordability criteria" means the factors used to determine the amount of premium assistance or state out-of-pocket assistance that will be provided from the fund on behalf of an eligible individual.

C. "Eligible plan" means a health plan sold on the New Mexico health insurance exchange (the "exchange" or "marketplace") that meets the requirements for the state premium assistance program.

D. "Federal poverty level or FPL" means the federal poverty level issued annually by the U.S department of health and human services at aspe.hhs.gov/poverty-guidelines/.

E. "Income criteria" means parameters to establish eligibility for marketplace affordability programs.

F. "Modified adjusted gross income or MAGI" means modified adjusted gross income as defined in 42 CFR § 435.60.

G. "Marketplace affordability program" means a fund program that reduces premiums and OOP costs for individuals and families who purchase individual or family coverage on the exchange.

H. "OOP" means out-of-pocket.

I. "Participating health insurance issuer" means a health insurance issuer who is authorized to sell a QHP on the exchange or in the fully-insured small group market who has confirmed in writing its intention to participate in a specified fund program prior to the commencement of the plan year.

J. "Plan year" means the year for which a participating health insurance issuer underwrites qualifying health insurance coverage.

K. "Premium assistance" means a fund program that pays a participating health insurance issuer to cover a portion of the premium obligation of a person who meets premium assistance affordability criteria.

L. "QHP" means a qualified health plan.

M. "Small business health insurance premium relief initiative" means a program to reduce premiums for small businesses that purchase QHPs in the small group health insurance market.

N. "Small group QHP purchaser" means an employer who purchases one or more QHPs for any of its employees or owners through the small business health options program or directly from a health insurance issuer selling QHPs in the small group health insurance market.

O. **"State benchmark plan"** means a qualified health plan that has been approved for sale on the exchange and that is identified by the superintendent as the plan to be used in developing affordability criteria.

P. **"State out-of-pocket assistance program"** means a fund program that reduces OOP costs for households that meet eligibility and income criteria established by the superintendent.

[13.10.36.7 NMAC – N, 5/1/2022; E/A, 6/1/2022; A, 9/1/2022]

13.10.36.8 APPROPRIATIONS REQUESTS: This rule governs appropriation requests.

A. Annually, the superintendent will submit appropriation requests to the legislative finance committee for each fund program. OSI will post proposed program parameters associated with the budget request on the agency's website upon submission to the legislative finance committee.

B. The request for each fund program shall meet these minimum standards:

(1) for the marketplace affordability program, sufficient funding to provide premium reductions for individuals under four hundred percent of the FPL and OOP cost reductions for individuals under three hundred percent of the FPL;

(2) for the small business health insurance premium relief initiative, sufficient funding to realize premium reductions for qualified health plans across the small group market; and

(3) for the uninsured program, sufficient funding to expand coverage to eligible individuals under two hundred percent of the FPL before expanding further up the income scale.

[13.10.36.8 NMAC – N, 5/1/2022; A/E, 6/1/2022, A, 9/1/2022]

13.10.36.9 PREMIUM ASSISTANCE AND ANNUAL OOP PROGRAMS: This rule governs the annual state out-of-pocket assistance and premium assistance programs.

A. **Affordability criteria:** Annually, the superintendent shall publish a bulletin specifying affordability criteria for the ensuing plan year. Absent extenuating circumstances that mandate an earlier rate filing, the superintendent shall allow issuers at least 15 days from publication of the bulletin to make an initial QHP rate filing. If the federal government changes policies that will affect the cost of the program to the state or the cost to enrollees after the issuance of the bulletin, the superintendent may adjust the affordability criteria.

(1) These are the affordability criteria that the superintendent may consider to determine premium assistance eligibility for a plan year. The superintendent will use these criteria to establish a premium sliding scale based on household income:

(a) the percentage of an enrollee's MAGI as computed according to federal standards;

(b) the percentage of enrollee's MAGI that would be needed to purchase the state benchmark plan as established by the superintendent;

(c) the percentage of New Mexico residents at or below a given the FPL percentage; and

(d) The federal premium sliding scale for marketplace coverage.

(2) These are the affordability criteria that the superintendent may consider to determine state out-of-pocket assistance eligibility. The superintendent will use these criteria to establish state cost sharing reduction variants that improve the actuarial value of certain QHPs offered on the exchange:

(a) an enrollee's MAGI as computed according to federal standards;

(b) plan type and metal level tiers that qualify for state out-of-pocket assistance; and

(c) actuarial values for plans that qualify for state out-of-pocket assistance.

B. **Income eligibility parameters.** Annually, the superintendent shall publish a bulletin specifying income eligibility parameters for the ensuing plan year. Absent extenuating circumstances that mandate an earlier rate filing, the superintendent shall allow participating health insurance issuers at least 15 days from publication of the bulletin to make an initial QHP rate filing. If the federal government changes policies that will affect the cost of the program to the state or the cost to enrollees after the issuance of the bulletin, the superintendent may adjust the income eligibility parameters. The income eligibility parameters may differ for the premium assistance program, state out-of-pocket assistance program or premium assistance for state residents who are members of federally-recognized tribes. In developing the criteria, the superintendent may consider the following factors:

(1) the income distribution of current marketplace enrollees;

(2) the income distribution of uninsured individuals who qualify for coverage on the New Mexico health insurance exchange; or

(3) health insurance market stability issues and year-over-year trends in premium rate affordability.

C. General eligibility requirements.

(1) To qualify for state out-of-pocket and premium assistance, consumers must:

(a) be eligible to purchase a QHP on the exchange;

(b) qualify for federal premium assistance; and

(c) meet income criteria established annually by the superintendent.

(2) The superintendent will issue criteria for premium assistance that is available to members of federally-recognized tribes. To qualify, individuals must:

(a) meet all other criteria for state premium assistance; and

(b) be a member of a federally-recognized tribe.

D. Premium and state out-of-pocket assistance payment disbursements. Disbursements for premium assistance or state out-of-pocket assistance to a participating health insurance issuer of an eligible enrollee who purchases an eligible plan are governed by this rule. Monthly, by the 15th of each month, the exchange shall report to the superintendent the total amount due to each participating health insurance issuer for premium assistance and state out-of-pocket assistance for coverage of its eligible enrollee(s) for the preceding calendar month.

(1) The monthly payment amount due to a participating health insurance issuer for premium assistance shall be the monthly aggregate amount of premium assistance for all eligible enrollees of the health insurance issuer for the month.

(a) Monthly state premium assistance amounts shall be calculated using the following formula: gross monthly premium for state benchmark plan minus monthly federal premium tax credit minus applicable percentage of income established by superintendent multiplied by expected annual household income as outlined in 45 C.F.R. § 155.305(f)(i) divided by 12.

(b) Within 10 days of receiving the monthly accounting from the exchange, the superintendent will, by voucher, request that the secretary of finance and administration issue warrants as necessary to ensure payment to each participating health insurance issuer for the monthly amount determined to be due by the superintendent.

(2) The monthly payment amount to a participating health insurance issuer for state out-of-pocket assistance shall be determined as a percentage set by the superintendent of gross monthly premiums for enrollees of an eligible plan in a specified income tier, aggregated across all qualifying income tiers.

(3) To facilitate reconciliation, a health insurance issuer must track or accurately estimate claim costs in accordance with guidance published by the superintendent to allow for the determination of actual utilization of out-of-pocket assistance.

[13.10.36.9 NMAC – N, 5/1/2022]

13.10.36.10 MINIMIZING COVERAGE DISRUPTIONS AFTER THE FEDERAL MEDICAID CONTINUOUS COVERAGE REQUIREMENT EXPIRES: This rule governs the agency's efforts to ensure a smooth transition into a QHP offered on the New Mexico health insurance exchange for individuals who no longer qualify for medicaid after the expiration continuous coverage requirement in the federal "families first coronavirus response act".

A. Temporary medicaid transition premium relief program. The superintendent may issue a bulletin establishing a program that fully covers the cost of the first month's premium for any QHP sold on the individual health insurance exchange for eligible individuals and families. The premium relief will be available to all members of a household that meet the eligibility requirements in Paragraph B of this section. The payment may be used to effectuate coverage.

B. Eligibility for medicaid transition premium relief program. To qualify, a person must:

(1) be a resident of the state of New Mexico who is eligible to purchase a QHP on the New Mexico health insurance exchange;

(2) have lost medicaid coverage or expect to lose medicaid coverage within 60 days of submitting an application to the New Mexico health insurance exchange;

(3) no longer be enrolled in medicaid at the time their QHP coverage begins;

(4) be eligible for federal premium tax credits; and

(5) have an expected household income below four hundred percent of the federal poverty level during the plan year in which the federal coronavirus disease (COVID-19) public health emergency ends.

C. Duration. The program shall be available on January 1, 2023, or on the day the COVID-19 public health emergency ends, whichever is later. The program shall continue in accordance with legislative appropriations.

[13.10.36.10 NMAC – N/E, 6/1/2022, A, 9/1/2022]

13.10.36.11 SMALL BUSINESS HEALTH INSURANCE PREMIUM RELIEF INITIATIVE: This rule governs the agency's small business health insurance premium relief initiative, which applies to QHPs sold through the small business health options program or purchased directly from a health insurance issuer selling QHPs in the small group health insurance market.

A. Premium reduction percentage bulletin. Annually, based on available funding, the superintendent will issue a bulletin establishing a premium reduction percentage that will apply to all QHPs sold in the small group health insurance market. Health insurance issuers participating in the market shall discount charges to small group QHP purchasers by the percentage established by the superintendent and show the amount of the discount in all invoices to the purchaser. The superintendent may allow issuers to apply the discount directly or through a credit on the following month's premium. The bulletin will establish the percentage reduction, reporting requirements, timetable and process for issuer reimbursement, and other requirements. The superintendent may issue additional guidance, if needed.

B. Reporting requirements and annual verification of accurate payments. Health insurance issuers selling QHPs in the small group health insurance market must report data related to enrollment, premiums, and reimbursement from the health care affordability fund to the office of superintendent of insurance on a regular basis, based on the requirements of the bulletin. Following each calendar year, on a date established by the superintendent, issuers must report annualized data requested by the agency to verify the accuracy of payments made from the fund. The superintendent will require issuers to replenish the fund if it is determined that any overpayment has been issued.

C. Payments to participating issuers. On a regular basis, as established in the bulletin, the office of superintendent of insurance will make payments from the health care affordability fund to issuers for the remainder of the gross premium that that would otherwise by owed by small group QHP purchasers if the small business health insurance premium relief initiative were not in effect. The data received by OSI pursuant to Paragraph B of Section 10 of this rule serves as the basis for OSI's regular payments to issuers from the health care affordability fund. Issuers must invoice the agency according to the bulletin's instructions in order to receive payment.

D. Notification of small group QHP purchasers. The superintendent will specify a date before the initiative goes into effect by which health insurance issuers must notify their small group QHP purchasers about the premium reductions provided by the initiative. Issuers subject to the rule should reflect the premium reduction amount in all invoices.

E. Treatment as third-party payment. For the purposes of the federal risk adjustment program and federal medical loss ratio requirements, the state payment under this section should be considered a third-party payment that is part of the gross premium.

[13.10.36.11 NMAC – N/E, 6/1/2022, A, 9/1/2022]

History of 13.10.36 NMAC: [RESERVED]